PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

2550 Denali Street, Suite 1404
Anchorage, AK 99503-2753

Waiver of Coverage

1. EMPLOYEE INFORMATION

Group/employer name		Group number	
City and Borough of Sitka		1011203	
Employee name	Employee date of birth	Gender ☐ Male ☐ Female	Number of hours worked per week

2. WAIVER CONFIRMATION

This is to confirm that I decline to participate in the Premera Blue Cross Blue Shield of Alaska program offered through my employer's group health plan as follows.

☐ I do not wish to enroll **myself**. I have other Group coverage as follows:
- ☐ CHAMPUS/Tricare
- ☐ Medicare as primary, at the request of the Medicare enrollee
- ☐ Another group health plan through my spouse or parent. Name of spouse's/parent's employer: _____

☐ I do not wish to enroll **myself**. I have other Individual coverage.

☐ I do not wish to enroll **myself**. I do not have other health coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children**.* They have other Group coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children**.* They have other Individual coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children**.* They have coverage through Medicaid/CHIP or other state-sponsored coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children**.* They do not have other health coverage.

*Please list the names of specific children you wish to waive if you are not enrolling all of them: _____

_____

3. EVIDENCE OF OTHER GROUP COVERAGE

Are you an employee of a small group employer (2-99 employees)? *If unknown, check with your Group Benefits Administrator to verify.*

☐ No, go to Section 4 ☐ Yes, please provide the following:

If you have declined due to having **other Group coverage for yourself**, attach one of the following to provide evidence of that other coverage.

☐ Copy of your insurance ID card from the other group coverage

☐ Copy of an Explanation of Benefits (EOB) for yourself from the other group coverage

4. EMPLOYEE SIGNATURE

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage (or receive a request to enroll from a state agency administering Medicaid or CHIP) and we must receive your enrollment application within 60 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

By signing below, you understand that you will be unable to obtain coverage under your employer's group health plan until the next open enrollment period, unless you and/or your dependents qualify for enrollment under the special enrollment rules described above.

Please note: A person who, with intent to injure, defraud, or deceive, knowingly makes a false or fraudulent statement or representation in or with reference to an application for insurance may be prosecuted under state law.

X	Date